Prince Edward Island's Second Report on Common Health Indicators

November 2004

Health and Social Services System

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Prince Edward Island's Second Report on Common Health Indicators

November 2004

Prepared by the PEI Department of Health and Social Services in fulfillment of the September 2000 First Ministers' Agreement on Health and the 2003 First Ministers' Accord on Health Care Renewal for federal/provincial/territorial comparable indicator reporting.

To obtain additional copies of this report in both official languages:

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Eighteen featured indicators are included in this report.
Results for the full suite of eighty-one selected indicators for 2004 reporting
for all jurisdictions are available on a national public Web site at:
English: ***www.cihi.ca/comparable-indicators***
French: ***www.icis.ca/indicateurs-comparables***

November 30, 2004

I am pleased to present Prince Edward Island's Second Report on Common Health Indicators.

The release of this report fulfills the Health Ministers' commitment to have all provinces and territories report on the health of their citizens and the performance of their health systems based on common indicators as per the September 2000 First Ministers' Agreement on Health. This report works toward fulfilling the February 2003 First Ministers' Accord on Health Care Renewal which included commitments on performance reporting in priority areas such as primary health care, home care, catastrophic drug coverage and pharmaceutical management, diagnostic and medical equipment, health human resources, and healthy Canadians. This report presents the public with a selection of indicators, common to all or most jurisdictions, and is organized in the three categories of access, quality, and health and wellness. Additional indicator results (81 in all) comparing all jurisdictions are posted on a national public Web site at ***www.cihi.ca/comparable-indicators***. This data will be used to inform both the public and decision makers on how PEI compares to the national average and to other jurisdictions, where PEI is doing well, and where changes may be needed.

I encourage you to join us in using this information to improve our health and health services.

Sincerely,

Chester Gillan
Minister of Health and Social Services

AUDITOR GENERAL

CHARLOTTETOWN

PRINCE EDWARD ISLAND

REPORT OF THE AUDITOR GENERAL ON THE RESULTS OF APPLYING SPECIFIED AUDITING PROCEDURES TO PRINCE EDWARD ISLAND'S SECOND REPORT ON COMMON HEALTH INDICATORS

To the Minister of Health and Social Services:

In connection with the featured indicators included in *Prince Edward Island's Second Report on Common Health Indicators, November 2004* I have:

1. Agreed information from Statistics Canada, the Canadian Institute for Health Information and Health Canada to this report. Where information is reported as not suitable for publication, confirmed that the information is identified as not suitable.

2. Checked that the presentation of results is consistent with the stated methodology.

3. Checked that the featured indicators agree to and include results for the eighteen featured indicators approved by the Conference of Deputy Ministers pursuant to the February 5, 2003 First Ministers' Accord on Health Care Renewal.

As a result of applying the above procedures, I found no significant exceptions. These procedures, however, do not constitute an audit and therefore I express no opinion on the featured indicators included in *Prince Edward Island's Second Report on Common Health Indicators, November 2004*.

Colin Younker, CA
Auditor General

Charlottetown, Prince Edward Island
November 19, 2004

November 30, 2004

Management's Responsibility for Prince Edward Island's Second Report on Common Health Indicators

Responsibility for the integrity of the attached Prince Edward Island's Second Report on Common Health Indicators rests with the Minister of Health and Social Services. The responsibility of the department includes maintaining systems and controls to ensure that information is objective, complete, and accurate in accordance with agreed reporting requirements developed by the federal/provincial/territorial Performance Reporting Technical Working Group (PRTWG).

In preparing the report, the department relied on information provided from external parties as indicated in the report such as Statistics Canada, the Canadian Institute for Health Information (CIHI) and Health Canada. The department's responsibility for such information is limited to being reasonably confident that it is free of significant misrepresentation.

To the best of our knowledge, the information in this report is reliable. The report has been prepared in accordance with the following criteria, unless otherwise stated in the report.

1 The information reported meets the requirements of the commitment of the First Ministers' Meeting Agreement on Health dated September 2000 and the 2003 First Ministers' Accord on Health Care Renewal. The health indicators comply with the definitions, technical specifications and standards of presentation developed by the PRTWG.

2 The reported indicators fairly reflect the facts to a reasonable level of accuracy.

3 The indicator measures are defined, and their significance and limitations explained. The report states and properly describes any departures from what was developed by the PRTWG.

Sincerely,

Dave Riley
Deputy Minister

Executive Summary

This report is the second federal/provincial/territorial (FPT) health indicator report. The report fulfills PEI's commitment to be accountable to Islanders as per the September 2000 First Ministers' Agreement on Health and the 2003 First Ministers' Accord on Health Care Renewal.

In September 2000, the first ministers issued an agreement on health requiring clear, accountable reporting to Canadians and directed their ministers of health to provide comprehensive and regular public reporting beginning in September 2002. The health ministers established an FPT committee called the Performance Indicator Reporting Committee (PIRC) which consulted extensively with all provinces and territories and relevant experts to arrive at a jointly agreed upon list of comparable measures. The first report was released in September, 2002 with 67 indicators identified for reporting in the three categories of health status, health outcomes, and quality of service.

The February 2003 First Ministers' Accord on Health Care Renewal directed health ministers to further develop indicators to supplement the work on comparable indicator reporting. The accord focused indicator development and reporting activities on several specific program and service areas considered to be priorities, identifying the development of these services as important strategies for health system reform and sustainability. The priority areas included primary health care, home care, catastrophic drug coverage and pharmaceutical management, diagnostic and medical equipment, health human resources, and healthy Canadians.

The FPT Conference of Deputy Ministers (CDM) of Health directed the Advisory Committee on Governance and Accountability (ACGA) to prepare the plan for comparable reporting, in compliance with the terms of the 2003 Accord. The policy direction for this work was developed and approved by the CDM. The Performance Reporting Technical Working Group (PRTWG) was established to undertake the technical work required to select and oversee development of comparable indicators for FPT reporting. The PRTWG included representation from the FPT jurisdictions, as well as the Canadian Institute for Health Information, Statistics Canada and the l'Institute de la Statistique du Quebec (ISQ). Public consultation included national stakeholder groups and the public via workshops, written submissions and focus groups.

This second report, released November 30th , 2004, includes twenty-one of the eighty-one indicators identified for comparable reporting. Data for all eighty-one indicators, for all jurisdictions is reported on a national public Web site: English ***www.cihi.ca/comparable-indicators***; French ***www.icis.ca/indicateurs-comparables***.

In this report, PEI data was compared to the national average. For all indicators the most current year of data available was reported, which in most cases ranged from 2001 to 2003, depending on the indicator.

The results presented in this report indicate that in some areas, there is room for improvement; and in other areas, PEI results are better than the Canadian average.

With respect to access, between approximately one sixth and one quarter of Islanders who accessed various first contact services had difficulty obtaining them. Reportable wait times for diagnostic services showed PEI rates statistically similar to the Canadian average. Close to half of Islanders reported waiting less than one month for diagnostic services. The indicator on household drug spending showed that PEI has higher rates of out of pocket spending on prescription drugs than the Canadian average.

Quality indicator results showed that the majority of Islanders reported being "very satisfied" or "somewhat satisfied" with various health services they had received. However, PEI showed a much higher rate of hospitalization for conditions that could be treated in the community (ambulatory care sensitive conditions) compared to the Canadian average.

Results in the Health and Wellness section showed that lifestyle habits and choices that pose health risks are a major issue for Islanders. About 11 per cent of Island teenagers reported being a current smoker, most of whom smoked daily. Less than one quarter of Islanders reported that they were physically active and approximately 58 percent were overweight or obese. The prevalence rate of diabetes in PEI was about five per cent with male rates higher than female rates. PEI rates were similar to the Canadian average. Rates of diabetes increased with age. Over half of Island seniors reported being immunized for the flu. PEI also had a high proportion of individuals that rated their health as very good or excellent. The life expectancy for PEI women is 7.4 years longer than for men; however, when health adjusted, the difference between males and females is only 4.4 years.

Definitions

Statistical Significance

The terms "higher" and "lower" are used in this report to indicate statistically significant differences, for example, between a PEI rate and a comparable rate for Canada. Where 95 per cent confidence intervals (degree of variability associated with a rate) were provided, statistical significance was determined if the rate for Canada fell between the lower and upper confidence limit of the PEI rate. For comparable rates between age groups and between sexes, where there was overlap between the two sets of upper and lower confidence intervals, rates were considered similar.

The Canadian Community Health Survey (CCHS)

The data source for many of the indicators in this report was the CCHS. This was a national survey conducted in 2000/01 and 2003 by Statistics Canada in 130 health regions. It asked Canadians aged 12 and over about a broad range of health-related issues. Data sources for each table presented in the report are listed in Appendix 1.

The Health Services Access Survey (HSAS)

This is a supplement to Cycle 2.1 of the Canadian Community Health Survey 2003 (CCHS), conducted by Statistics Canada. The HSAS was designed to collect information about access to first contact services and specialized services. A sub-sample of CCHS respondents aged 15 yrs. and older from the 10 provinces was selected and interviewed for the HSAS. Data sources for each table presented in the report are listed in Appendix 1.

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1. Access

1.1 Obtaining First Contact Health Services

Difficulty obtaining routine or on-going health services

The ability to obtain routine care when needed is believed to be important in maintaining health, preventing health emergencies and preventing the inappropriate use of services such as hospital emergency rooms for non-emergencies.

Difficulty obtaining health information or advice

Access to information or advice is believed to be important to maintaining health and ensuring appropriate access to health services at any time of the day.

Difficulty obtaining immediate care for a minor health problem

The ability to obtain immediate needed care for minor health problems is believed to be important in restoring health, preventing health emergencies, and preventing the inappropriate use of services.

These indicators report on the percentage of survey respondents, age 15 and over, who required the service for self or a family member in the previous 12 months and experienced difficulties obtaining it.

Table 1 **Self- reported Difficulty Obtaining Health Services, 2003**

	routine or on-going health services	*health information or advice*	*immediate care*
PEI	17.4%	18.5%	27.4%
CAN	15.8%	16.2%	24.2%

The PEI rates for all three health services were similar to the Canadian rates. When comparing across first contact services in PEI, the proportion of individuals who reported difficulty obtaining them was higher for immediate care for a minor health problem compared to health information or advice and routine care. This trend was the same for the Canadian results.

1.2 Wait Times for Diagnostic Services

Diagnostic services include non-emergency MRIs, CT Scans, and angiographies only. Wait time refers to the length of time, in weeks, between the patient being referred for a specialized service and receiving the service.

Median Wait Time for Diagnostic Services

The median is the 50th percentile of the distribution of wait times: half of patients waited less and half waited longer than the median number of weeks.

Distribution of wait times for diagnostic services

Distribution indicates the percent of those requiring a diagnostic service that waited less than 1 month, between 1 to 3 months or more than 3 months to receive the service.

This indicator reports on the percentage of survey respondents who received service during the previous 12 months and reported their length of wait time.

Table 2 Self-reported Wait Times for Diagnostic Services, 2003

	Median wait time	Distribution of wait times		
		less than 1 month	*1-3 months*	*longer than 3 months*
PEI	4.3 weeks (E)	47.9%	38.1% (E)	(F)
CAN	3.0 weeks	57.5%	31.1%	11.5%

E - Data should be interpreted with caution. Refers to data with a coefficient of variation (CV) from 16.6% to 33.3%.

F - Data is suppressed. Refers to data with a coefficient of variation (CV) greater than 33.3% which results in extreme sampling variability.

The PEI median wait time and the distribution wait times for less than one month, and for one to three months, were statistically similar to the Canada wait times. Close to half of Islanders reported waiting less than one month for diagnostic services.

1.3 Prescription Drug Spending as a Percentage of Income

The purpose of this indicator is to measure the extent to which households are burdened by prescription drug costs.

This indicator reports the percent of households spending over certain percentages of their total after tax income, out-of-pocket, on prescription drugs.

Table 3 **Prescription Drug Spending as a Percentage of Income, 2002**

	rate of households spending over...					
	0%	*1%*	*2%*	*3%*	*4%*	*5%*
PEI	78.0%	27.5%	17.7%	11.7%	8.0%	6.6%
CAN	65.2%	19.1%	10.5%	6.5%	4.5%	3.0%

Over three quarters of Island households (78 per cent) spent some out-of-pocket income on prescription drugs. The PEI rate was higher than the Canada rate by about 12.8 per cent. For all spending categories, PEI rates were higher than the Canada rates with more than twice the rate of PEI households spending five per cent or more of their income.

2. *Quality*

2.1 Patient Satisfaction

Patient satisfaction with services is one indicator of the quality of services.

These five satisfaction indicators report on the percentage of survey respondents, age 15 and over, who rated themselves as either "very satisfied" or "somewhat satisfied" with the services they received in the previous 12 months.

Patient satisfaction with overall health care services
This includes any health care service received.

Patient satisfaction with community-based care
In this instance, the definition for community-based care includes any health care received outside of a hospital or doctor's office. Such care includes home nursing care, home-based counseling or therapy, personal care, and community walk-in clinics.

Patient satisfaction with hospital care
This refers to any type of care received within the hospital setting.

Patient satisfaction with physician care
This includes care received from a family doctor or medical specialist (and excludes services received in a hospital).

Table 4 Self-reported "Very Satisfied" or "Somewhat Satisfied" with Health Services, 2003

	overall health care services received	*community-based care received*	*hospital care received*	*physician care received*
PEI	88.3%	88.4%	85.0%	94.2%
CAN	85.3%	82.9%	82.3%	91.8%

The majority of Islanders and Canadians were satisfied with the various health services they had received. For community-based care services and hospital care services, the PEI satisfaction rates were statistically similar to the Canada rates. The PEI satisfaction rates for overall health care services and physician care services, were statistically higher than the Canada rates.

Patient satisfaction with telephone health line or tele-health services

In Canada, tele-health service denotes a phone service where clients can get medical advice from professional health practitioners such as a nurse or a physician. Some jurisdictions in Canada have this service and others, including PEI, do not.

Telephone health lines refer to services which provide only information on health-related topics. In PEI, as in other jurisdictions, these services can range from disease-specific organizations, such as the Cancer Society or AIDS organization, to community family health centres, to services with a specific mandate to research and disseminate health information upon request by the public.

Table 5 Self-reported "Very Satisfied" or "Somewhat Satisfied" with Telephone Health Line or Tele-health Services, 2003

PEI	76.9% (E)
CAN	83.9%

E - Data should be interpreted with caution. Refers to data with a coefficient of variation (CV) from 16.6% to 33.3%.

Regarding telephone health line and tele-health services, the latter does not exist in PEI. Therefore, the survey results refer to telephone health line services only. It is very difficult to tell which of the wide range of possible services Islanders were responding to.

2.2 Hospitalization Rate for Ambulatory Care Sensitive Conditions (ACSC)

Hospitalization rates for conditions which may often be cared for in the community are one indicator of appropriate access to community-based care. These are long-term health conditions which can often be managed with timely and effective treatment in the community including diabetes, asthma, alcohol and drug dependence and abuse, neuroses, depression and hypertensive disease. Although preventive care, primary care, and community based management of these conditions will not eliminate all hospitalizations, such steps could eliminate many of them. Health care professionals generally believe that managing these conditions before a patient requires hospitalization improves the patient's health, contributes to better overall community health status, and often saves money because community-based care usually costs less than hospitalization.

This indicator reports the age-standardized inpatient hospitalization rate for conditions where appropriate ambulatory care prevents or reduces the need for admission to hospital.

Table 6 Age-standardized Hospitalization Rates for ACSC, 2001/2002

PEI	888 per 100,000 population
CAN	346 per 100,000 population

The PEI rate was more than twice the rate for Canada. While not shown in Table 6, the range among the provinces/territories was from a low of 243 to a high of 1,114 per 100,000 population.

3. *Health and Wellness*

3.1 Health Adjusted Life Expectancy

Health adjusted life expectancy (HALE) is the number of years in perfect health that an individual can expect to live, given the current morbidity and mortality conditions. HALE is not only a measure of quantity of life, but also a measure of quality of life. Hale combines measures of both age-specific and sex-specific health status, and age-specific and sex-specific mortality into a single statistic.[1]

Health adjusted life expectancy by income is also reported here as a way of introducing a socio-economic factor to a health outcome.

Table 7 **Health Adjusted Life Expectancy, by Sex, 2001**

		Health Adjusted Life Expectancy at Birth			
		all income groups	*income tercile 1 (lowest)*	*income tercile 2 (middle)*	*income tercile 3 (highest)*
PEI	males	67.3 yrs	65.2 yrs	67.5 yrs	69.5 yrs
	females	71.7 yrs	71.8 yrs	70.5 yrs	72.5 yrs
CAN	males	68.3 yrs	65.8 yrs	68.6 yrs	70.5 yrs
	females	70.8 yrs	69.1 yrs	70.8 yrs	72.3 yrs

Overall, life expectancy for PEI women is 82.6 years and 75.2 years for PEI men. When life expectancy was health adjusted, the difference for PEI women was approximately 11 years less and approximately 8 years less for PEI men. When presented by income tercile, the HALE for men increased as the income tercile increased. However, for PEI women, the HALE was higher in the lowest income tercile than in the middle income tercile.

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[1] **Note:** The HALE is a relatively new indicator, and embodies a number of assumptions which are important for its interpretation. One such assumption is the use of an indicator of the self-reported health status of a sample of individuals, each at a moment in time, to represent the double average, first, of that individual's health status over a period of time, such as a year, and then over-all of the individuals in the population (e.g. of a province). A second and related assumption is that there is a reciprocity between health and time such that, for example, 5 years lived at a heath state of 0.5 (quite poor health) as measured by the indicator is the same thing as 2.5 years lived in full health. For more information on HALE, please refer to the following Web site: English: ***www.statcan.ca/hale*** or French: ***www.statcan.ca/evas***.

3.2 Prevalence of Diabetes

The prevalence of diabetes gives an idea of the burden of this disease at a given time and is widely used in public health monitoring and planning. The National Diabetes Surveillance System (2003) has estimated that approximately 5 per cent of all Canadians are affected by diabetes, thereby generating direct costs related to physician and hospital care, prescription drugs, and other costs borne by individuals, as well as indirect costs including premature death or disability.

This indicator reports the prevalence rate of diagnosed diabetes among health service users aged 20 years or over.[2]

Table 8 Prevalence of Diabetes, 1999/2000

	females	*males*	*total*
PEI	4.7%	5.5%	5.1%
CAN	4.9%	5.4%	5.1%

The prevalence of diabetes in PEI was similar to the Canada rate. In PEI and Canada, diabetes rates increased with age up to age 80. In PEI, the range was from 0.8 per cent for age group 20-29 years to 15.5 per cent for the 80-84 year age group. In PEI and in Canada, the diabetes rates were higher for males for all age groups 40 years and over.

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[2] **Note**: Caution should be used when interpreting this data. Data limitations are as follows:

1) Three types of diabetes are included in the database: Type 1, Type 2, and gestational diabetes. Note that gestational diabetes is only included when coded as diabetes mellitus (ICD9 code 250).
2) A baseline error rate of 20 per cent to 25 per cent exists in the published (1999/2000) data.
3) This level of error is accepted by Health Canada and by those national experts identified by Health Canada.
4) Since 1997-98, this data has been accumulating false positives. For the data published here this may not have a significant impact. Health Canada plans to work to reduce these errors so that by the time it publishes the 2001-02 data, this accumulation will not become significant.
5) This baseline error rate is likely to vary by age and sex groups.

3.3 Teenage Smoking

Tobacco use is the leading cause of preventable illness and death in Canada. Health Canada estimates that smoking is responsible for more than 45,000 deaths per year. This indicator was selected from the broader results for smoking because the addictive nature of nicotine means that youth smoking is of particular concern. It is estimated that approximately eight out of every 10 people who try smoking become habitual smokers.

Current smokers
Refers to those who smoke daily or occasionally.

Daily smokers
Refers to those who smoke on a daily basis.

This indicator reports the percentage of survey respondents aged 12 - 19 (inclusive) who reported at the time of the survey that they were current or daily smokers.

Table 9 Self-reported Teenage Smoking Rates, 2003

	current smoker *(Includes daily and occasional smoker)*	***daily smoker***
PEI	11.4% (E)	10.1% (E)
CAN	14.8%	9.1%

E - Data should be interpreted with caution. Refers to data with a coefficient of variation (CV) from 16.6% to 33.3%.

The PEI rates for current smoker and daily smoker were similar to the Canada rates. In PEI and Canada, females in this age group had higher smoking rates than males.

3.4 Physical Activity

Maintaining physical activity is associated with a range of health benefits. For example, many studies have shown that regular physical activity has major heart health benefits, that inactivity is a major risk factor for heart disease, and that physically active individuals are less likely to become depressed.

Physical activity rates are based on information that survey respondents provided about the frequency, duration and intensity of their participation in leisure-time physical activity over the previous 3 months. Respondents are then classified as physically active (3.0 kcal/kg/day or more), moderately active (1.5 - 2.9 kcal/kg/day), or inactive (less than 1.5 kcal per day).

This indicator reports the percentage of survey respondents aged 12 and over who reported at the time of the survey a physical activity index of "active" or "inactive".

Table 10 **Self-reported Physical Activity Rates, by Sex, 2003**

		active	*inactive*
PEI	both	22.0%	53.2%
	males	25.4%	50.4%
	females	18.7%	55.8%
CAN	both	26.1%	46.9%
	males	29.8%	43.5%
	females	22.7%	50.2%

The total PEI rate for "active" was significantly lower than the Canada rate and the total PEI "inactive" rate was significantly higher. In Canada and PEI, both males and females in the 12-19 age group reported the highest rates for being "active".

In both PEI and Canada, the "inactive" rates increased with age, except for the male age group 65 years and over. This group actually dropped below the "inactive" rates of younger males aged 35 to 64 years.

3.5 Body Mass Index

Obesity has been identified as a major risk factor contributing to a number of chronic illnesses such as diabetes and heart disease. The effect of excess weight as a risk factor increases with a body mass index (BMI) above the threshold of 25. BMI is the most common method of determining if an individual's weight is in a healthy range.

BMI data is based on self-reported height and weight, and calculated as weight in kilograms divided by height in meters squared. The BMI categories are as follows: under 18.5 is underweight; 18.5-24.9 is acceptable weight; 25.0-29.9 is overweight; 30.0 and over is obese.

This indicator reports the percentage of survey respondents aged 18 years and over (excluding pregnant women and persons under 3 feet or over 6 feet 11 inches tall) who reported height and weight which was converted to a body mass index in specified categories, ranging from "underweight" to "obese".

Table 11 Self-reported Body Mass Index Rates, 2003

	underweight	*acceptable weight*	*overweight*	*obese*
PEI	1.7 % (E)	37.1 %	37.1 %	20.6 %
CAN	2.6 %	46.7 %	33.3 %	14.9 %

E - Data should be interpreted with caution. Refers to data with a coefficient of variation (CV) from 16.6% to 33.3%.

The PEI rate for "acceptable weight" was statistically lower than the Canada rate. The PEI rates for "overweight" and "obese" were statistically higher than the Canada rates.

Across the age groups, for PEI and Canada, males tended to have higher rates of "overweight" and "obesity". In PEI and Canada, females had higher rates in the "acceptable weight" category. In PEI, the age groups with the highest rates of "overweight" were the 45 to 64 years and 65 years and over age groups. In PEI, the age group with the highest rate of "obesity" was the 35 to 44 year age group.

3.6 Influenza Immunization for Age 65 Years and Over

Immunization for Influenza (the flu) has been shown to be effective for adults over 65 years of age.

This indicator reports on the percentage of survey respondents 65 years of age and over who reported having a flu shot in the previous 12 months.

Table 12 Self-reported Influenza Immunization Rates, 65+, 2003

PEI	57.8%
CAN	62.4%

The PEI rate was statistically similar to the Canada rate. In PEI, the female rate was higher than the male rate.

3.7 Self-reported Health

Self-reported health is a general indicator of the overall health status of individuals, and reflects how healthy individuals feel they are. It includes what other measures may miss, such as disease severity, coping skills, psychological attitude and social well-being. Self-reported health data is collected by asking individuals to rate their own health on a five point scale ranging from "excellent" to "poor". Numerous studies have found that self-reported health can predict mortality rates even when more objective measures are taken into account.

This indicator reports the percentage of survey respondents aged 12 and older who rated their own health as "very good" or "excellent".

Table 13 Self-reported Health, by Age Group, 2003

	reported "very good" or "excellent" health					
	total 12 yrs +	*12-19 yrs*	*20-34 yrs*	*35-44 yrs*	*45-64 yrs*	*65 yrs +*
PEI	64.9%	62.8%	74.8%	73.7%	61.6%	46.7%
CAN	58.4%	66.9%	68.7%	63.6%	53.4%	36.6%

The total rate for PEI was statistically higher than the Canada rate. In PEI and Canada, the 20 to 34 year age group reported the highest rate of "very good" or "excellent" health.

Appendix 1 *Data Sources*

Table 1: Statistics Canada, Health Services Access Survey, 2003.

Table 2: Statistics Canada, Health Services Access Survey, 2003.

Table 3: Statistics Canada, Survey of Household Spending, 2002.

Table 4: Statistics Canada, Canadian Community Health Survey, 2003.

Table 5: Statistics Canada, Canadian Community Health Survey, 2003.

Table 6: Canadian Institute for Health Information, Hospital Morbidity Database; Statistics Canada, Census; l'Institute Statistique du Quebec.

Table 7: HALE: Statistics Canada: National Population Health Survey (NPHS), Institutional Component for Health Utility Index (HUI) of persons in institutions (1996-1997 cross-sectional sample); 2001 Census for counts of residents living in long-term health care institutions (to match with sampling frame of the NPHS); Canadian Community Health Survey 2000/01 Cycle 1.1 (common content) for HUI and counts of persons in households.

HALE by income tercile: Statistics Canada: National Population Health Survey (NPHS), Institutional Component for Health Utility Index (HUI) of persons in institutions (1996-1997 cross-sectional sample); 2001 Census for counts of residents living in long-term health care institutions (to match with sampling frame of the NPHS); Canadian Community Health Survey 2000/01 Cycle 1.1 (common content) for HUI and counts of persons in households; 2000/2001 abridged life tables adjusted to 1996 income terciles.

Table 8: Health Canada: *Responding to the Challenge of Diabetes in Canada: First Report of the National Diabetes Surveillance System*. Ottawa, 2003.

Table 9: Statistics Canada, Canadian Community Health Survey, 2003.

Table 10: Statistics Canada, Canadian Community Health Survey, 2003.

Table 11: Statistics Canada, Canadian Community Health Survey, 2003.

Table 12: Statistics Canada, Canadian Community Health Survey (sub sample) Cycle 2.1, 2003.

Table 13: Statistics Canada, Canadian Community Health Survey, 2003.

An electronic version of this document can be found,
in both official languages,
on the Government of PEI Web site at:
www.gov.pe.ca/hss

For more data and information on these
and many other indicators,
visit the national public Web site:
English: ***www.cihi.ca/comparable-indicators***
French: ***www.icis.ca/indicateurs-comparables***